

AFTERCARE REPORT

Due: Monthly

ID #: _____

(Fold and mail in window envelope when completed)

Name: _____

DOPL

ATTN: PROBATION/URAP

PO BOX 146741

SALT LAKE CITY UT 84114-6741

Profession: _____

Questions? Call 530-6428 or 530-6718

FAX: (801) 530-6511

DOPL is appreciative of the effort and support your program offers our probationers and diversionees. We consider your observations especially valid since you see them in a facilitated setting weekly. It is important that you keep us apprised of situations which could affect their recovery and advise us of anything which would be important in our efforts to assist them.

MONTH: _____

Week 1, Date _____ Comments/Observations:	RELAPSE SYMPTOMS NOTED <input type="checkbox"/>
Week 2, Date _____ Comments/Observations:	RELAPSE SYMPTOMS NOTED <input type="checkbox"/>
Week 3, Date _____ Comments/Observations:	RELAPSE SYMPTOMS NOTED <input type="checkbox"/>
Week 4, Date _____ Comments/Observations:	RELAPSE SYMPTOMS NOTED <input type="checkbox"/>
Week 5, Date _____ Comments/Observations:	RELAPSE SYMPTOMS NOTED <input type="checkbox"/>

Random Drug Screens obtained? YES ____ NO ____ RESULTS: _____

Please discuss any comments, recommendations or problems for this probationer:

Signature

Institution

Phone Number

Date